EDITORIAL

# In This Issue: What Patients Value and How to Provide It

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Four studies in this issue provide unique insights into what patients value in health care.[1-4] Three studies reveal possible ways to achieve this value.[3-5] Four studies in this issue are from outside the United States,[1,3,4,5] and 1 shows the negative effects of acculturation to the United States.[6] This issue also features 2 studies of innovative primary care research methods,[7,8] and several other studies instruct us in novel methods by applying them to interesting questions.[1-4,9] The US Preventive Services Task Force provides us with 2 updates,[10,11] and a clinical trial tests a simple intervention hypothesized to reduce inflammatory markers.[10] One powerful essay provides an intergenerational look at work-family balance.[12] Another essay compels us to think and feel about healing in the context of relationship, intention, and meaning.[13] Finally, 2 participants in the TransforMED National Demonstration Project (NDP) reflect on the crisis in primary care, their insights from the NDP, and the ingredients for practice change. In the end, they find that relationships remain the centerpiece of family medicine.[14]

## WHAT PATIENTS VALUE

A study of patient preferences finds that English patients are willing to pay most for a thorough physical examination. They also value seeing a doctor who knows them well. These and other priorities vary with the situation and patient characteristics.[1] It would be interesting to know whether these relationships hold in other countries.

Liu et al[2] use patient report, census data, and Health Professional Shortage Area classifications to identify factors associated with *bypass*—that is, seeking health care services outside the local community. They find that this phenomenon occurs in approximately one-third of respondents living within 20 miles of a Critical Access Hospital in a Health Professional Shortage Area, and that a low density of primary care physicians and patient perceptions of limited services and specialty care are associated with not using local care.

Russell and colleagues examine both the patient and the physician experience with chronic illness care planning in Ontario, Canada.[3] They find that patient-centered care planning is difficult to implement within the biomedical framework of physicians and is generally not noticed by patients, but it is favorably assessed when it is noticed.

In a study of practices and patients in Quebec, Haggerty and colleagues identify the organizational and professional characteristics of primary care practice that are associated with patient accessibility, continuity, and coordination of care.[4]

## IMPROVING PRACTICE

The Russell et al[3] and Haggerty et al[4] studies show the challenges of reorganizing practice to facilitate chronic illness care[3] and to enhance patient experience.[4] Haggerty et al find a number of feasible organizational factors that are associated with better accessibility, relational continuity, and coordination continuity. There are some tradeoffs among these factors.

In an era in which primary care physician burnout is a major concern, Kjeldmand and colleagues show us that long-term participation in a Balint group can enable the joy of being a doctor.[5] Participants reported positive effects on competence in patient encounters, sense of security, identity, and satisfaction. Although the study did not assess the effect on patients, it is hard to imagine that patients would not want their physician to have more of these qualities.

## REVEALING METHODS

Among many methodologically interesting studies in this issue, King et al show us how to develop a single study into a line of inquiry.[9] Based on both biological plausibility and epidemiological data, the authors used a large, nationally representative data set to test an interesting hypothesis about the association of fiber and

C-reactive protein.[15] Then, with an eye toward a clinically practical intervention, they test the association in a randomized clinical trial, finding minimal effect.[9]

Two studies in this issue are explicitly designed to evaluate methods for primary care research.

A randomized trial by Galliher and colleagues[7] compares the use of handheld computers with paper forms for data collection in a national practice-based research network. They find interesting tradeoffs between the 2 data collection methods.

Another methodology study examines the use of narrative reports to monitor and evaluate a practice change intervention.[8] Narrative reports submitted by pharmacists over a 1-year period proved useful in documenting early learning and in using this learning to refine the integration of pharmacists into the family medicine setting.

Other methodologically interesting studies in this issue include the use of a discrete choice experiment in which patients are asked to choose between consultations differing in specific attributes,[1] nesting of a patient sample within a stratified physician sample and using hierarchical regression to account for the nesting in the analysis,[4] and linking 3 complementary data sets to answer a question that requires multiple vantage points.[2]

## GRIPPING ESSAYS

Three essays reflect critical themes in modern health care.

Inspired by a conversation with his mid-career primary care physician, Ibriham shares personal regrets and reflections on the trade-offs he made in balancing work and family on the path of his successful career.[12]

In a simple essay that takes us into an examination room rich in intergenerational pain and love, Guerrera provides insights about the importance of presence, intention, and relationships in promoting healing.[13]

At the midpoint of a national demonstration project, 2 family physicians share insights from their own experience with practice transformation and from a retreat of practices randomized to the self-directed group of the project.[14]

Please share your insights by joining the *Annals* online discussion at http://www.AnnFamMed.org.

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